ASSURANCE OF SERVICE PROVISION

FOR

BLOOD LEAD CAPILLARY DRAWS

This is to certify that as health officer of a local health department, I will assure that blood lead specimens obtained by capillary draw method will be conducted by qualified staff according to Medicaid published policies and procedures.

INSTRUCTIONS:

- **Photocopy this form**, complete it, then mail it to the address below:

  PROVIDER ENROLLMENT
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30238
  LANSING, MI 48909

- A handwritten signature IS REQUIRED.

Enter all **Medicaid ID Numbers** under which blood lead capillary draws will be billed:
(Please Type or Print)

Medicaid ID Number	Physician Name
Medicaid ID Number	Physician Name
Medicaid ID Number	Physician Name

Name of Local Health Department	Telephone Number ( ) -
Address (Number and Street, City, State, ZIP Code)	

Handwritten Signature of Health Officer	Date Signed
Printed Name of Health Officer	

AUTHORITY:	Title XIX of the Social Security Act	The Department of Community Health is an equal opportunity employer, services, and programs provider.
COMPLETION:	Is voluntary, but is required if Medical Assistance Program payment is desired.	